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CHALENG 2005 Survey: VA Western New York HCS - (VAMC Batavia - 528A4 and VAMC Buffalo - 528)

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 880

2. Estimated Number of Veterans who are Chronically Homeless: 123

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 880 (estimated number of homeless veterans in service area) **x chronically homeless rate (14 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	438	30
Transitional Housing Beds	612	30
Permanent Housing Beds	550	100

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 3

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	The City of Buffalo has seen a lost of privately-held rental units. Subsequently, there is an increased competition for both public and private rental units. Many veterans have a poor record of tenancy, including problems with eviction.
Transitional living facility or halfway house	We will continue to encourage our community partners to apply for grants for transitional housing. We will continue to work toward expanding our community partnership network.
Immediate shelter	Two local shelters are planning to expand. We will support their efforts, encourage our community partners to be supportive, and offer encouragement.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **60** **Non-VA staff Participants: 63.0%**
Homeless/Formerly Homeless: **25.0%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.53	4.0%	3.47
Food	3.69	9.0%	3.80
Clothing	3.58	4.0%	3.61
Emergency (immediate) shelter	3.07	34.0%	3.33
Halfway house or transitional living facility	2.66	41.0%	3.07
Long-term, permanent housing	2.48	54.0%	2.49
Detoxification from substances	3.42	4.0%	3.41
Treatment for substance abuse	3.54	13.0%	3.55
Services for emotional or psychiatric problems	3.4	13.0%	3.46
Treatment for dual diagnosis	3.3	9.0%	3.30
Family counseling	2.82	.0%	2.99
Medical services	3.78	7.0%	3.78
Women's health care	3.15	2.0%	3.23
Help with medication	3.46	4.0%	3.46
Drop-in center or day program	3.29	2.0%	2.98
AIDS/HIV testing/counseling	3.61	.0%	3.51
TB testing	3.82	.0%	3.71
TB treatment	3.65	.0%	3.57
Hepatitis C testing	3.73	.0%	3.63
Dental care	2.38	16.0%	2.59
Eye care	2.85	.0%	2.88
Glasses	2.98	2.0%	2.88
VA disability/pension	3.23	5.0%	3.40
Welfare payments	3.11	2.0%	3.03
SSI/SSD process	2.90	2.0%	3.10
Guardianship (financial)	2.59	4.0%	2.85
Help managing money	2.71	.0%	2.87
Job training	3.28	13.0%	3.02
Help with finding a job or getting employment	3.32	16.0%	3.14
Help getting needed documents or identification	3.22	2.0%	3.28
Help with transportation	2.77	25.0%	3.02
Education	2.97	4.0%	3.00
Child care	2.38	.0%	2.45
Legal assistance	2.70	5.0%	2.71
Discharge upgrade	3.12	.0%	3.00
Spiritual	3.37	.0%	3.36
Re-entry services for incarcerated veterans	2.76	4.0%	2.72
Elder Healthcare	3.02	.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.33
Co-location of Services - Services from the VA and your agency provided in one location.	1.97
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.52
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.07
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.55
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.40
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.73
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	1.90
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.67
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.37
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.60
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.68

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.47
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.36

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CHALENG 2005 Survey: VAMC Albany, NY - 500

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 1250

2. Estimated Number of Veterans who are Chronically Homeless: 350

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 1250 (estimated number of homeless veterans in service area) **x chronically homeless rate (28 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	40	50
Transitional Housing Beds	86	20
Permanent Housing Beds	0	25

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 27

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	Continue to work with local agencies to develop and advocate for more affordable permanent housing. Continue to work with "10-year plan" groups.
Immediate shelter	Work with local faith-based groups as well as County Continuum to maximize emergency resources. We are anticipating an increase in heating costs, leading to evictions this winter.
Transitional living facility or halfway house	Work with local providers to develop grant proposal for structured transitional housing.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **53** **Non-VA staff Participants: 54.9%**
Homeless/Formerly Homeless: **5.7%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.60	3.0%	3.47
Food	4.05	8.0%	3.80
Clothing	4.00	3.0%	3.61
Emergency (immediate) shelter	3.64	31.0%	3.33
Halfway house or transitional living facility	3.77	21.0%	3.07
Long-term, permanent housing	3.05	64.0%	2.49
Detoxification from substances	4.07	3.0%	3.41
Treatment for substance abuse	4.17	8.0%	3.55
Services for emotional or psychiatric problems	4.1	.0%	3.46
Treatment for dual diagnosis	3.9	5.0%	3.30
Family counseling	3.17	8.0%	2.99
Medical services	4.32	13.0%	3.78
Women's health care	3.57	3.0%	3.23
Help with medication	3.77	3.0%	3.46
Drop-in center or day program	3.43	5.0%	2.98
AIDS/HIV testing/counseling	3.88	3.0%	3.51
TB testing	4.21	.0%	3.71
TB treatment	4.17	.0%	3.57
Hepatitis C testing	4.02	3.0%	3.63
Dental care	3.19	11.0%	2.59
Eye care	3.48	5.0%	2.88
Glasses	3.55	.0%	2.88
VA disability/pension	3.88	3.0%	3.40
Welfare payments	3.37	.0%	3.03
SSI/SSD process	3.67	5.0%	3.10
Guardianship (financial)	3.38	5.0%	2.85
Help managing money	3.21	16.0%	2.87
Job training	3.71	18.0%	3.02
Help with finding a job or getting employment	3.89	11.0%	3.14
Help getting needed documents or identification	3.86	3.0%	3.28
Help with transportation	3.60	13.0%	3.02
Education	3.41	3.0%	3.00
Child care	2.35	11.0%	2.45
Legal assistance	3.09	11.0%	2.71
Discharge upgrade	3.56	.0%	3.00
Spiritual	3.55	3.0%	3.36
Re-entry services for incarcerated veterans	3.50	3.0%	2.72
Elder Healthcare	3.57	3.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	3.35
Co-location of Services - Services from the VA and your agency provided in one location.	2.57
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.43
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.82
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	2.36
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.95
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	2.05
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.91
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2.48
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.68
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.91
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	2.10

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	4.00
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	4.08

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CHALENG 2005 Survey: VAMC Canandaigua, NY - 528A5, Bath, NY, Rochester, NY

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 40

2. Estimated Number of Veterans who are Chronically Homeless: 4

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 40 (estimated number of homeless veterans in service area) **x chronically homeless rate (11 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	664	0
Transitional Housing Beds	28	10
Permanent Housing Beds	39	0

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 4

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	HUD Shelter Plus Care (subsidized housing similar to Section 8) will be used as primary source of permanent housing. We are hoping to increase not only the total number of available slots but also the number of agencies who can apply for and receive this
Detoxification from substances	We are planning to work with a local detox agency which is state-funded, to have a certain number of "beds" or slots available for homeless veterans who need this service. Our own detox services throughout VA are very fragmented and difficult to access
Legal Assistance	We have met with local representatives from a number of voluntary legal agencies in our area and are in the process of developing new liaisons to assists veterans with legal problems.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **13** **Non-VA staff Participants: 66.7%**
Homeless/Formerly Homeless: **.0%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.17	20.0%	3.47
Food	4.08	9.0%	3.80
Clothing	3.92	.0%	3.61
Emergency (immediate) shelter	3.67	10.0%	3.33
Halfway house or transitional living facility	2.82	30.0%	3.07
Long-term, permanent housing	1.83	64.0%	2.49
Detoxification from substances	3.25	10.0%	3.41
Treatment for substance abuse	3.92	10.0%	3.55
Services for emotional or psychiatric problems	4.1	10.0%	3.46
Treatment for dual diagnosis	3.6	.0%	3.30
Family counseling	3.42	.0%	2.99
Medical services	3.67	10.0%	3.78
Women's health care	3.33	10.0%	3.23
Help with medication	3.27	.0%	3.46
Drop-in center or day program	2.09	40.0%	2.98
AIDS/HIV testing/counseling	3.67	.0%	3.51
TB testing	3.73	.0%	3.71
TB treatment	3.70	10.0%	3.57
Hepatitis C testing	3.45	.0%	3.63
Dental care	2.42	10.0%	2.59
Eye care	2.50	10.0%	2.88
Glasses	2.67	10.0%	2.88
VA disability/pension	3.36	.0%	3.40
Welfare payments	3.18	9.0%	3.03
SSI/SSD process	2.92	.0%	3.10
Guardianship (financial)	2.82	10.0%	2.85
Help managing money	3.00	.0%	2.87
Job training	3.36	10.0%	3.02
Help with finding a job or getting employment	3.82	9.0%	3.14
Help getting needed documents or identification	3.09	.0%	3.28
Help with transportation	2.55	10.0%	3.02
Education	3.45	.0%	3.00
Child care	2.22	.0%	2.45
Legal assistance	2.55	10.0%	2.71
Discharge upgrade	3.40	.0%	3.00
Spiritual	3.56	.0%	3.36
Re-entry services for incarcerated veterans	3.10	.0%	2.72
Elder Healthcare	3.27	.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.14
Co-location of Services - Services from the VA and your agency provided in one location.	2.29
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.86
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.00
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.14
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	2.00
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.29
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.29
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.57
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.43
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.71
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.50

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.75
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.29

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CHALENG 2005 Survey: VAMC Syracuse, NY - 670

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 30

2. Estimated Number of Veterans who are Chronically Homeless: 11

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 30 (estimated number of homeless veterans in service area) **x chronically homeless rate (38 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	556	20
Transitional Housing Beds	323	10
Permanent Housing Beds	224	30

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 5

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	As a result of grant approval for a new housing development project and other projected expansion of permanent housing beds, collaboration with community partners will continue to provide supported permanent housing options for veterans.
Transitional living facility or halfway house	Continue to evaluate transitional housing and employment needs and promote new VA GPD/HVRP funding opportunities among community partners.
Eye Care	Increase the number of homeless veterans referred for eye glasses/care through the Lions Club Gift of Sight program.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **18** **Non-VA staff Participants: 44.4%**
Homeless/Formerly Homeless: **.0%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.50	.0%	3.47
Food	3.76	6.0%	3.80
Clothing	3.35	.0%	3.61
Emergency (immediate) shelter	3.06	19.0%	3.33
Halfway house or transitional living facility	3.00	44.0%	3.07
Long-term, permanent housing	2.35	50.0%	2.49
Detoxification from substances	3.33	.0%	3.41
Treatment for substance abuse	3.56	.0%	3.55
Services for emotional or psychiatric problems	3.6	13.0%	3.46
Treatment for dual diagnosis	3.2	13.0%	3.30
Family counseling	3.00	.0%	2.99
Medical services	3.94	6.0%	3.78
Women's health care	3.19	.0%	3.23
Help with medication	3.19	6.0%	3.46
Drop-in center or day program	2.94	6.0%	2.98
AIDS/HIV testing/counseling	3.50	6.0%	3.51
TB testing	3.94	.0%	3.71
TB treatment	3.75	.0%	3.57
Hepatitis C testing	4.00	.0%	3.63
Dental care	2.06	31.0%	2.59
Eye care	2.41	13.0%	2.88
Glasses	2.35	13.0%	2.88
VA disability/pension	3.61	.0%	3.40
Welfare payments	2.94	.0%	3.03
SSI/SSD process	3.18	.0%	3.10
Guardianship (financial)	2.94	.0%	2.85
Help managing money	2.82	.0%	2.87
Job training	3.24	6.0%	3.02
Help with finding a job or getting employment	3.47	6.0%	3.14
Help getting needed documents or identification	3.29	.0%	3.28
Help with transportation	2.71	6.0%	3.02
Education	3.00	.0%	3.00
Child care	2.19	.0%	2.45
Legal assistance	2.69	6.0%	2.71
Discharge upgrade	2.81	13.0%	3.00
Spiritual	3.00	6.0%	3.36
Re-entry services for incarcerated veterans	2.65	19.0%	2.72
Elder Healthcare	3.19	.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.71
Co-location of Services - Services from the VA and your agency provided in one location.	1.63
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.63
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.63
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.75
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.71
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.71
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	1.50
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.71
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.17
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.86
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.86

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.71
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.50